DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/09/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155773	A. BUILDING	00	08/29/2011
		100770	B. WING		00/29/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
TEDDAC	E AT SOLARBRON	THE		CDOWELL ROAD VILLE, IN47712	
				VILLE, IN+1112	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
F0000	REGULATORI OR	ESC ISENTI TING IN ORDINION	1710		DATE
10000					
	This visit was for	r a Recertification and	F0000		
	State Licensure S	Survey.			
		,			
	Survey Dates:				
	_	4, 25, 26, 29, 2011			
		, , , ,			
	Facility Number:	010930			
	Provider Number				
	AIM Number: N	/A			
	Survey Team:				
	Diane Hancock,	RN TC			
	Amy Wininger, I				
	8/25, 8/26, 8/29/				
	, ,				
	Census Bed Type	2:			
	SNF = 28				
	Residential= 36				
	Total= 64				
	Census Payor Ty	pe:			
	Medicare = 11				
	Other= 53				
	Total= 64				
	Sample: 10				
	Residential Samp	ole: 7			
	These deficiencie	es also reflect state			
	findings cited in	accordance with 410 IAC			
	16.2.				
LAROR ATOP	V DIRECTOR'S OR PROV	TIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Event ID:

HENT11

Facility ID:

010930

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record review, the facility failed to ensure this Response and Plan of		ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773 A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2011				
TERRACE AT SOLARBRON, THE EVANSVILLE, IN47712 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OUality review 8/31/11 by Suzanne Williams, RN The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review the facility failed to ensure EVANSVILLE, IN47712 ID PROVIDERS PLAN OF CORRECTION (X5) (X5) PREFIX (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETIO DATE OUAlity review 8/31/11 by Suzanne Williams, RN The facility failed to ensure	NAME OF PROVIDER OR SUPPLIER							
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROJECT TAG Quality review 8/31/11 by Suzanne Williams, RN The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review, the facility failed to ensure.	TERRACE AT SOLARBRON, THE		I, THE					
REGULATORY OR LSC IDENTIFYING INFORMATION) Quality review 8/31/11 by Suzanne Williams, RN The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review the facility failed to ensure.	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1		PROVIDER'S PLAN OF CORRECTION		(X5)
Quality review 8/31/11 by Suzanne Williams, RN The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review the facility failed to ensure		`				CROSS-REFERENCED TO THE APPROPRIAT	N SHOULD BE COM HE APPROPRIATE	
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1 of 2 sampled residents utilizing oxygen therapy, in the total sample of 10, received the oxygen at the ordered flow rate. (Resident #22) Finding includes: Resident #22 was observed, on 8/22/11 at 11:16 a.m., to be up in a chair in his room, with his oxygen set at 3 liters per minute via nasal cannula. RN #1 indicated, during interview at that time, the resident had returned from the hospital after having pneumonia. Resident #22 was observed, on 8/23/11 at 9:00 a.m., to be in the therapy area, seated in a wheelchair. He had a portable oxygen tank with him. The oxygen was set on 3 liters per minute. He was observed again, at 12:15 p.m. on 8/23/11, to be in his room with his oxygen rate set Torrection do not constitute and admission oragreement by the provider of the truth of the facts alleged orconclusions set forth in the statement of deficiencies. This Plan of Correctionand Compliance. For purposes of any allegation of correction and compliance with the regulations as set forth in the statement of deficiencies, this Plan of Correction and compliance. For operation of correction and compliance with the regulations as set forth in the statement of deficiencies. This Plan of Correctionand Compliance is for purposes of federal and state law. Credible Allegation of Correctionand Compliance is for purposes of federal and state law. Credible Allegation of Correctionand Compliance is for purposes of federal and state law. Credible Allegation of Correctionand Compliance is for purposes of federal and state law. Credible Allegation of Correctionand Compliance. For purposes of federal and state law. Credible Allegation of Correctionand Compliance with the regulation sa set forth in the statement of deficiencies. This Plan of Correctionand Compliance with the regulation sa set forth in the statement of deficiencies. This Plan of Correctionand Compliance. For purposes of any allegation that the treatment of deficiencies, this Plan of Correction constitutes and facility's credible allegation of correction constitutes a		The facility must ender proper treatment as special services: Injections; Parenteral and en Colostomy, ureten Tracheostomy car Tracheal suctioning Respiratory care; Foot care; and Prostheses. Based on observation of 2 sampled reterable of 2 sampled reterable of the rapy, in the toreceived the oxygrate. (Resident #Finding includes Resident #22 was 11:16 a.m., to be with his oxygen via nasal cannular during interview had returned from having pneumon Resident #22 was 9:00 a.m., to be in a wheelchair. oxygen tank with set on 3 liters per observed again, as special services.	teral fluids; ostomy, or ileostomy care; e; e; eg; eg; ation, interview and he facility failed to ensure esidents utilizing oxygen of tall sample of 10, gen at the ordered flow f22) Es observed, on 8/22/11 at the up in a chair in his room, set at 3 liters per minute ha. RN #1 indicated, at that time, the resident method the hospital after ia. Is observed, on 8/23/11 at the hospital after ia. Is observed, on 8/23/11 at the hospital after ia. Is observed, on 8/23/11 at the hospital after ia. Is observed, on 8/23/11 at the hospital after ia. Is observed, on 8/23/11 at the hospital after ia. Is observed, on 8/23/11 at the hospital after ia. Is observed, on 8/23/11 at the hospital after ia.	F03:	28	thisResponse and Plan of Correction do not constitute a admission oragreement by the provider of the truth of the fact alleged orconclusions set for the statement of deficiencies. This Plan of Correction is prepared and/or executed so because it is required by the provisions of federal and stat law. Credible Allegation of Correctionand Compliance: Purposes of any allegation that The Terrace at Solarbron is not compliance with the regulation as set forth in this statement deficiencies, this Plan of Correction constitutes and facility's credible allegation of correction and compliance. 328 Whatcorrective action (swill be accomplished for the residents found to have been affected by the deficient practice? Resident #22 was on hourly checks to ensure the resident was receiving the coamount of oxygen liter flow a	an ne cts th in . dely te for at not in ons of f F s) ose en s put ne orrect nd	09/05/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155773 08/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 MCDOWELL ROAD TERRACE AT SOLARBRON, THE EVANSVILLE, IN47712 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE levels. The resident's wife was at 3 liters per minute. educated regarding the importance of the maintaining the On 8/25/11 at 12:45 p.m., Resident #22 ordered level of oxygen liter flow was in his room. His oxygen was set at 4 for her spouse as well as the liters per minute. LPN #1 was possible harmful effects of non-compliance of the physician's interviewed at 12:55 p.m. She indicated order. How will other residents his oxygen was supposed to be on 2 and having the potential to be 1/2 liters per minute. At 1:15 p.m., LPN affected by the deficient #1 indicated she had gone to check the practice be identified and what corrective actions will be resident and the oxygen had been on 4 taken? All residents utilizing liters per minute and she had dropped it oxygen had the potential to be down to 2.5 liters as ordered. She affected. Anaudit was completed indicated she would be rechecking his on all residents utilizing oxygen and no other residents were oxygen saturation level; it had been 98 found to be affected by the percent on the 4 liters. alleged deficiency. Residents receiving oxygen will be checked Resident #22's clinical record was every shift for liter flow accuracy and oxygen saturation levels. reviewed on 8/23/11 at 11:30 a.m. The These finding will be placed on resident had been admitted to the facility the resident Treatment on 8/16/11, with diagnoses including, but Administration Record. What not limited to, pneumonia, chronic measure will be put into place obstructive pulmonary disease, and or what systemic changes will be made to ensure that the shortness of breath. Physician's orders, deficient practice does not signed 8/16/11, indicated the resident's recur? All nursing staff will be oxygen orders were for "O2 [oxygen] @ 2 in-serviced on care planning the 1/2 L/NC [liters per nasal cannula] cont. utilization of oxygen and the importance of ensuring the [continuous] Keep O2 sat [saturation] > residents receive services as [greater than] 90%." prescribed by their physician. In addition, staff will be instructed to On 8/26/11 at 3:30 p.m., the resident's add oxygen liter flow rates and saturation levels on the 24 hour oxygen settings were discussed with the report. Upon admission, Director of Nurses and the Administrator. residents with orders for oxygen They wondered aloud whether or not the will be care planned and resident's family member had increased monitored for proper utilization. A

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PROVIDER OR SUPPLIER		STREET A 1701 M	ADDRESS, CITY, STATE, ZIP CODE CDOWELL ROAD VILLE, IN47712	
E AT SOLARBRON SUMMARY S (EACH DEFICIENT REGULATORY OR the oxygen, and it	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) further indicated they sident on hourly checks to	1701 M	CDOWELL ROAD	evised ygen every rair levels. Plan to on the usting yt the stored factice raility eput who ed by is/her or liter uration weekly y x 3 dent n as audits I the